Paediatric Physiotherapy Referral Form

Please print and complete in black ink. **Forms lacking adequate detailed information will delay appropriate next steps for this child.** We suggest that professionals referring a child complete this form in partnership with parents/carers.
If you do not have access to all the information we require, please ensure that you complete in as much detail as you can.
We accept referrals from Consultants, GPs and AHP's.

Child's Details

Child's first name/s:	Child's Family name:
Date of Birth:	NHS No:

Address:	Male / Female (please circle)
	Telephone No:
Postcode:	Mobile:
First Language:	Interpreter needed? Yes / No (please circle)

Please circle ethnic code:			
White - British	A	Asian/Asian British- Pakistani	J
White - Irish	B	Asian/Asian British – Bangladeshi	K
Any Other White Background	C	Any Other Asian Background	L
Mixed - White & Black Caribbean	D	Black/Black British Caribbean	M
Mixed – White & Black African	E	Black/Black British African	N
Mixed – White & Asian	F	Any other Black Background	P
Any Other Mixed Background	G	Other Ethnic Groups – Chinese	R
Asian/Asian British- Indian	H	Other Any Other Ethnic Group	S
		Not Stated	Z

Any existing diagnosis?	
Any known allergies?	
Any medication?	

Child's G.P

Name of GP: Tel No:
Address of GP:

Post code :

Details of all persons with Parental Responsibility

Name:	Name:
Relationship to child:	Relationship to child:
Address: Postcode: Contact No: Mobile No:	Address: Postcode: Contact No: Mobile No:

Any issues with home visits?

Childcare/Pre-School/Educational Setting:

Name	Address	Telephone Number	Contact Person

When do they attend?

Is this child on the Special Educational Needs & Disability (SEND) Code of Practice?

No		SEN Support		Has a statement of SEN or EHC Plan	

Key people/agencies involved (past or present) Please attach any relevant information from these people (e.g. Playplans/IEPS, reports, details of strategies or interventions), ensuring parental/carer's consent has been given.

Name	Role/Agency	Contact Details	Reason for involvement

Legal Care Status

Is the child/young person adopted? Yes / No Placing authority: Date of Adoption Order:	Is the child/young person looked after? Yes / No Placing authority: Interim Care Order / Care Order / Section 20 / Placement Order / Other: Were the Foster Carers approved by Solihull? Yes / No If no, by whom?
Allocated Social Worker	Social Work Team
Email & contact number	Foster Carers' Link Worker & Contact Number

Is this child on a child protection plan? Yes / No

Is this child entitled to NHS treatment? Yes / No

Consent for this Referral: (*Informed consent in this section must be obtained before submitting a request for a referral)*
I/We give consent for a referral for assessment to be made for the above named child to the service(s) indicated above.

Signed:

Relationship to child: **Date:**

Referrer Details:	
Name:	**Address:**
Designation:	**Contact Number:**

Referrers Signature:

Referral Details

The Paediatric Physiotherapy Service will see children who have acute/chronic NEUROLOGICAL, NEUROMUSCULAR and/or NEURODEVELOPMENTAL gross motor difficulties and fall into one of the following categories:

- Children aged between 0-16 years who have a Solihull GP.
- Children up to 19 years of age if they are in full-time education within a Solihull special school
- Children aged between 0-16 years who have complex physical difficulties which require school based equipment and attend a Solihull mainstream school or specialist nursery provision in Solihull.
- The paediatric physiotherapy service also accept children aged between 0-6 years who have a Solihull GP and have musculoskeletal condition such as torticollis, erbs palsy, perthes disease, gait asymmetries and acute/chronic pain. (For children over 6 years of age please refer to:

  Adult Community Musculoskeletal Service, telephone- 0121 329 0107, fax 0121 329 0198)

Medical Details

Does this child have a terminal/deteriorating condition? **Yes** ☐ **No** ☐

Is this child in severe and/or continuous pain? **Yes** ☐ **No** ☐

Type of Appointment Required

Are there any reasons why this child could not attend a local clinic for an appointment
For example- manual handling considerations, significant infection risks, oxygen dependent, safe guarding considerations, equipment needs or complex medical conditions **Yes** ☐ **No** ☐

If yes then please state……
……

Are there any issues re: visiting the child at home? **Yes** ☐ **No** ☐

If yes then please state……
……

Consent to Share Information

I/We give consent for the paeditric physiotherapy service to obtain medical details relating to this referral from other services involved with the above named child if required and to share information related to this referral with these services if required. This will improve your childs physiotherapy care.

Signed:

Relationship to child: **Date:**

Please enclose any copies of reports/ correspondence that may help describe the child's strengths and difficulties and and return this form to:

Paediatric Physiotherapy
Chelmsley Wood Primary Care Centre
Crabtree Drive
Birmingham
B37 5BU
Tel: 0121 722 8010
Fax: 0121 424 5916